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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **John Ray Schafer, M.D.** **270 Perkins Street** **Sonoma, CA 95476** **Physician's and Surgeon's Certificate No. G 6244,** Respondent.	Case No. 800-2017-035916 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about August 19, 1960, the Medical Board issued Physician's and Surgeon's Certificate Number G 6244 to John Ray Schafer, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2021, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

". . ."

(a)Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

" . . . "

6. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022[1] without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

" . . . "

7. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

8. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

" . . . "

9. Section 2241(b) of the Code states that "[n]othing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose."

10. Section 2238 of the Code states that "[a] violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

11. California Health and Safety Code section 11156, states:

"(a) Except as provided in Section 2241 of the Business and Professions Code, no person shall prescribe for, or administer, or dispense a controlled substance to, an addict, or to any person representing himself or herself as such. . ."

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[1] Dangerous drug means any drug unsafe for self-use in humans or animals including drugs that require a prescription to be lawfully dispensed.

BACKGROUND FACTS

12. At all times relevant to this matter, Respondent was licensed and practicing medicine as a family practitioner at Sonoma Family Practice in Sonoma, California.

13. Respondent treated Patient A[2] for a variety of ailments including hypertension, arthritis, dietary issues, chest pain, and chronic-obstructive pulmonary disease beginning, based on medical records provided, according to chart notes, on August 3, 2012 and ending on January 9, 2013, for a total of six (6) visits. A CURES[3] report states that Respondent began prescribing controlled substances to Patient A as early as August 30, 2011.[4]

14. On August 3, 2012, Patient A presented to Respondent and requested medication refills of Alprazolam[5] for anxiety and depression (which Patient A requested as a replacement for Diazepam[6]). Patient A also requested Methadone[7] to try to get off and/or take less of Norco[8]. Respondent prescribed Alprazolam (2 milligrams four times daily/CURES report shows 60 tablets) and methadone (10 milligrams twice daily/CURES report shows 124) for the diagnosis of arthritis. Respondent did not include any record of review of systems, physical exam or a complete and adequate history of the patient's present illness. Respondent explained in his

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[2] The patient in this document is designated as Patient A to protect his privacy. Respondent knows the name of the patient and can confirm Patient A's identify through discovery.

[3] CURES is the Controlled Substance Utilization Review and Evaluation System, a prescription drug monitoring database.

[4] Patient A's records indicate a Health History form was completed on August 30, 2011 but there are no chart notes related to that date indicating that a physical exam occurred, however, the medical records request was only for February 16, 2012 to February 16, 2013 so additional medical records may exist that were not provided.

[5] Alprazolam (trade name Xanax) is a benzodiazepine. It is a psychotropic drug used to treat anxiety disorders, panic disorders, and anxiety caused by depression. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance.

[6] Diazepam (trade name Valium) is a benzodiazepine. It is a psychotropic drug used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance.

[7] Methadone is a synthetic narcotic analgesic with multiple actions quantitatively similar to those of morphine. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance. Methadone exhibits a non-linear relationship due to the long half-life and accumulates with chronic dosing.

[8] Norco is a trade name for hydrocodone bitartrate with APAP (hydrocodone with acetaminophen) tablet. Norco 10/325 reflects that each pill contains 10 mg of hydrocodone bitartrate and 325 mg of acetaminophen. Hydrocodone bitartrate is a semisynthetic narcotic analgesic and a dangerous drug as defined in section 4022 and a Schedule III controlled substance.

subject interview that he prescribed Norco (10 mg, up to 10 tablets a day, up to 240 tablets every 30 days) to Patient A based on a previous doctor's note indicating Patient A needed that amount of Norco to remain working because of a motor vehicle accident from eleven years prior. Respondent also stated that he had prescribed diazepam for chronic anxiety. Respondent did not document his rationale in his medical record, and was unable to locate a copy of the letter from the previous doctor.

15. On August 17, 2012, Patient A filled a prescription written by Respondent for Norco 10/325 for 240 tablets. Then, less than two weeks later, on August 30, 2012, Patient A filled another prescription written by Respondent for Norco for 240 tablets.

16. Patient A was next seen by Respondent on September 7, 2012 for prescription refills and for a reported hospitalization for a lung infection. Respondent documented no review of systems or physical exam. Respondent prescribed methadone for arthritis and ordered a CURES report for the dates of September 8, 2011 to August 31, 2012, which showed additional prescriptions from other providers. Respondent stated in his subject interview that he reviewed the CURES report and counseled Patient A to cease getting controlled substances from other providers, and that Patient A agreed.

17. On September 17, 2012, Patient A filled a prescription for Norco 10/325 for 240 tablets which was prescribed by Respondent. On September 29, 2012, Patient A filled another prescription for Norco 10/325, 240 tablets also prescribed by Respondent.

18. Respondent treated Patient A next on October 5, 2012 for test results and noted a swollen and painful left hand but no physical examination was conducted or documented. Respondent diagnosed Patient A with arthritis and prescribed Norco 10/325 with 2 tablets every 4 hours. Patient A refilled the Norco prescription written by Respondent on October 6, 2012 and on October 17, 2012, Patient A again refilled the Norco prescription.

19. On October 24, 2012, Patient A was treated by Respondent and reported he was in a motorcycle accident on October 22, 2012 with a complaint of pain to his left hip, right hand, and face. Patient A reported he was carrying groceries on his handlebars and crashed into a tree.

Respondent conducted no review of systems, no physical exam, and documented no treatment plan.

20. On October 26, 2012 and November 8, 2012, Patient A refilled the same Norco prescriptions written by Respondent. On November 16, 2012, Patient A reported to Respondent that he had pain on his right pinky for two months and wanted to go back on methadone. Again, Respondent failed to conduct or document a review of systems or physical exam. Respondent diagnosed arthritis and hypertension and prescribed methadone (10 milligrams/120 tablets/1 – 2 daily). On that same date, November 16, 2012, Patient A filled his diazepam (120 quantity), Norco (240 quantity) and methadone (120 quantity) prescriptions written by Respondent.

21. On November 20, 2012, Patient A again obtained more diazepam (60 tablets), and an additional 60 tablets of diazepam three days later on November 23, 2012 from prescriptions written by Respondent.

22. On January 9, 2013, Patient A was last seen by Respondent for medication refills. Again, there was no review of systems conducted or documented, however, Respondent did conduct a physical exam and noted that Patient A had some wheeze and rales and diagnosed him with chronic-obstructive pulmonary disease and bronchitis and prescribed Norco.

23. Between November 25, 2012 and January 9, 2013, Patient A refilled Respondent's Norco 10/325 prescription as follows: 11/25/2012 (240 tablets); 11/29/2012 (240 tablets); 12/13/2012 (240 tablets); 12/23/2012 (240 tablets) 12/29/2012 (240 tablets); 1/10/2012 (240 tablets); 1/21/2013 (240 tablets); 2/4/2013 (240 tablets) and 2/25/2013 (240 tablets). On January 23, 2013, Patient A filled his methadone prescription (120 tablets of 10 milligrams each).

24. On February 16, 2013, Patient A was found unresponsive in a motel room and was pronounced dead. The cause of death was determined to be hydrocodone intoxication. The Coroner's report stated that Patient A had a hydrocodone level of .32 milligrams/liter in his blood (with a potentially toxic range of 0.1 milligrams/liter). Benzodiazepines were also detected.

25. In summary, between August 3, 2012 and January 9, 2013, Respondent prescribed 3,310 morphine tablets (200 milligrams each); 5,132 hydrocodone tablets (10 milligrams each);

90 tablets of Oxycontin[9] (80 milligrams each); 1,110 tablets of alprazolam (1 milligram each); 2,520 tablets of alprazolam (.5 milligrams each); 90 tablets of alprazolam (.25 milligrams each); 90 tablets of diazepam (5 milligrams each); 120 tablets of lorazepam[10] (.5 milligrams each) Respondent's doses varied from 420 to 620 morphine equivalent doses (MEDs).[11]

26. Between July 9, 2012 and August 30, 2012, Patient A received from Respondent 960 tablets of Norco and 124 tablets of methadone with an average of 252 MEDs per day. Then, between August 31, 2012 to November 23, 2012, Respondent prescribed 1800 tablets of Norco for an average of 560 MEDs, including, at times, 9100 milligrams daily of Tylenol (with a maximum daily recommended dose not to exceed 4000 milligrams); and 470 tablets of diazepam (10 milligrams). Between November 25, 2012 and February 25, 2013, Respondent prescribed 2,160 tablets of Norco and 120 tablets of methadone for an average of 293 MEDs per day. In one four-week period, Patient A received four prescriptions of 240 tablets each for a total of 960 tablets in 30 days (an average of 320 MEDs); 10,400 milligrams of Tylenol per day; and 530 tablets of diazepam. During this same time period, guidelines for opiate therapy in patients without cancer stated that over 200 milligrams per day would be considered a high dose.[12]

27. Patient A's CURES report details that Patient A utilized up to six different pharmacies, had up to four other providers of care in addition to Respondent, was concurrently prescribed Norco, diazepam and methadone from July 9, 2012 to August 30, 2012.

28. Respondent reported during his subject interview that Patient A suffered from withdrawal symptoms when he lowered his dose of Norco. Respondent only ran Patient A's CURES report one time during his treatment. Respondent admitted that he was aware other

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[9] OxyContin is a trade name for oxycodone hydrochloride controlled-release tablets. Oxycodone is a dangerous drug as defined in section 4022 and a Schedule II controlled substance. It is a more potent pain reliever than morphine or hydrocodone.

[10] Lorazepam (trade name Ativan) is a benzodiazepine. It is a sedative used to treat anxiety. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance.

[11] Morphine equivalent doses (MEDs) is used to convert the many different opioids into one standard value based on morphine and its potency. Oxycodone, for example, is 1.5 times as potent as morphine so 100 milligrams of oxycodone is equivalent to 150 MEDs.

[12] Huntzinger, Amber: *American Academy of Family Physicians* (Dec 1 2009); 80 (11) 1315-1318.

doctors were prescribing controlled substances to Patient A concurrently, at times. Respondent admitted also that he did not complete any drug screens of Patient A.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence/Incompetence/Improper Prescribing/Excessive Prescribing/Prescribing to an Addict/Prescribing for Non-Medical Purpose)

29. Respondent John Ray Schafer, M.D. is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, subdivisions (b) (gross negligence) and/or (d) (incompetence) and/or 2242 (improper prescribing) and/or 725 (excessive prescribing) and/or 2241, subdivision (b) (prescribing for a non-medical purpose) and/or 2238 of the Code and/or 11156 of the Health and Safety Code (prescribing to an addict) in that Respondent has committed gross negligence and/or exhibited incompetence and/or excessively prescribed controlled substances and/or prescribed to an addict and/or prescribed for non-medical purposes as described above, including, but not limited to, the following:

A. Respondent failed to establish a diagnosis or medical necessity for chronic opioid use for Patient A for non-cancer treatment of pain given the potential risks of long-term use of opioids.

B. Respondent failed to conduct and document sufficient clinical evaluation of Patient A or order appropriate testing. Respondent failed to review past medical records, failed to conduct detailed questioning of Patient A, failed to obtain imaging diagnostic tests including, but not limited to, magnetic imaging resonance testing (MRI), failed to obtain specific tests including laboratory tests, failed to document clinical or imaging testing, failed to consider appropriate therapies for Patient A's report of musculoskeletal pain including, but not limited to, screening tools such as pain intensity and interference or the Sheehan Disability Scale.

C. Respondent failed to undertake or document risk assessment for continued prescribing of long-term use of controlled substances, including use of screening and monitoring tools. Respondent failed to classify Patient A's risks using risk stratification analysis of benefits

versus risks to evaluate the potential for opioid abuse and the risk of adverse effects. Respondent failed to evaluate the potential risks of mixed narcotics including Norco and methadone, and the risks of combining opiates (Norco) with other respiratory depressants such as benzodiazepines (alprazolam and diazepam).

D. Respondent failed to develop a treatment plan and objectives for Patient A including, for example, improvement in pain and function, improvement in pain associated symptoms such as sleep disturbance and depression/anxiety, and avoidance of excessive use of medication. Patient A did not demonstrate any improvement while under Respondent's care, in fact, he continued to have anxiety and Respondent escalated the narcotic doses without any explanation for the change to the treatment plan. Respondent failed to specify measurable goals and objectives, failed to identify an exit strategy for discontinuing narcotic therapy including tapering or termination. Respondent repeatedly prescribed in escalated doses without any stated treatment objective or patient need, including dose recommendations above the daily recommended dosage with no clinical evidence of a change in condition requiring such excessively high doses.

E. Respondent failed to discuss and/or document that he discussed, the risks and benefits of long-term opioid use, combined narcotic use, and combined narcotic and benzodiazepine use with Patient A. Respondent failed to discuss and/or document that he discussed the risk of potential side effects including impaired motor skills with a concern for activities such as driving, and the risks of misuse, dependence, addiction and overdose. Respondent did not discuss and/or failed to document that he discussed, the limited evidence of benefits of long-term opioid therapy.

F. Respondent failed to ensure appropriate compliance monitoring with tools such as drug testing and/or conducting pill counting. Respondent failed to take appropriate action when a CURES report revealed that Patient A obtained drugs from multiple providers and multiple pharmacies.

G. Respondent failed to meaningfully reassess Patient A periodically including whether there was progress toward functional goals, whether there were side effects, progress in pain status, and a lack of evidence of patient misuse, abuse or diversion. Respondent failed to base care on outcomes such as making progress toward functional goals or the presence and nature of

side effects or pain status. Instead, despite warning signs for long-term narcotic and benzodiazepine use, Respondent continued prescribing high-dose narcotics, mixed narcotics, and mixed narcotic and benzodiazepine treatment. Respondent failed to reassess treatment of Patient A despite evidence of increased risk of abuse, misuse and diversion including usage of multiple providers and multiple pharmacies.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Failure to Maintain Adequate Records)

30. Respondent John Ray Schafer, M.D. is subject to disciplinary action under section 2266 of the Code (inadequate medical records) in that Respondent failed to maintain adequate medical records, as described above, including but not limited to:

A. Respondent failed to document a clear and detailed history of present illness for the various complaints made by Patient A.

B. Respondent failed to document a review of systems and largely failed to note any physical exam findings.

C. Respondent failed to document a treatment plan, including rationale for diagnosis, or discussion of with Patient A related to the medications chosen or discontinued including risks, benefits and side effects.

D. Respondent failed to maintain clear, detailed, and accurate written records for the planning and maintaining quality of patient care.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 6244, issued to John Ray Schafer, M.D.;

2. Revoking, suspending or denying approval of John Ray Schafer, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering John Ray Schafer, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED:
May 14, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
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